Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: CHRISTOPHER LOAR, MD 3100 TIMMONS LANE SUITE 250 HOUSTON, TX 77027	MFDR Tracking #: M4-10-1938-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ACCIDENT FUND INSURANCE CO OF Box #: 06	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The Requestor did not submit a position statement in accordance with rule §133.307.

Amount in Dispute: $783.20

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
1/15/09	99244	53.68 ÷ 36.0666 x $187.06 = $278.41	$251.97	$251.97
1/15/09	95904	53.68 ÷ 36.0666 x $46.40 = $69.06 x 4 =$276.24	$325.01	$276.24
1/15/09	95903	53.68 ÷ 36.0666 x $61.75 = $91.91 x 2 = $183.82	$181.22	$181.22
1/15/09	99070	N/A	$25.00	$0.00
			Total Due:	$709.43

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.3 sets out the guidelines for communication between healthcare providers and insurance carriers.
3. 28 Tex. Admin. Code § 134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 2/15/2009

   - 1MB – Reimbursement has been calculated according to the state fee guidelines.
   - 1VZ – The primary provider is a non-contracted provider.
   - 2SA – Procedure included in another code billed on same date of service

Explanation of benefits dated 3/12/2009

- 1IB –The submitted charges are duplicates of previously submitted bills.

Issues

1. Did the Carrier's EOB include sufficient and specific information to easily allow the reason for denial?
2. Was the Requestor reimbursed for the services rendered?
3. Is CPT code 99070 a bundled code per the NCCI edits?
4. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §133.3(a) Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section. The Requestor submitted the carrier's EOB dated 2/15/09 for the disputed services which shows $0.00 was reimbursed. The Requestor billed CPT codes 99244, 95904, 95903 and 99070. For CPT code 99244 the carrier's denial reason is 1MB "reimbursement has been calculated according to the state fee schedule guidelines." However, the amount paid column supports $0.00 was paid. For CPT code 95904 the carrier's denial reason is 1VZ "The primary provider is a non-contracted provider". The carrier did not respond with a position statement to this dispute, therefore this denial is not supported. For CPT code 95903 the carrier did not list a denial reason and the paid column supports $0.00 paid. It is unclear to the Division what the denial reason for this code is.
2. The Requestor submitted a second EOB dated 3/12/2009 which supports that the carrier denied all of the charges supporting that this a "duplicate claim/service". The Carrier did not process the EOB's in accordance with rule §133.3. In absence of sufficient and specific denial reasons, the Division concludes that reimbursement for CPT codes 99244, 95904 and 95903 is recommended. The requestor is seeking less than the MAR amounts for CPT codes 99244 and 95903. Therefore, the requestor will be reimbursed the sought amount for these codes.
3. The Requestor also billed CPT code 99070. The carrier denied this service with reason code 2SA "Procedure included in another code billed on same date of service." The description of CPT code 99070 is as follows: Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered. (list drugs, trays, supplies, or materials provided). Per NCCI edits, CPT code 99070 is always bundled into payment of other services. Therefore, reimbursement for CPT code 99070 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $709.43.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $709.43 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**11/9/10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought

exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.